STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155669	A. BUILDING 01 B. WING	07/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW TCU	395 WESTFIELD RD TCU NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/10/12 Facility Number: 011046 Provider Number: 155669 AIM Number: NA Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Riverview TCU was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This facility is located on the fourth floor of a fully sprinklered building determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility	K0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	does not have smoke detectors in resident sleeping rooms. The facility has a capacity of 25 and had a census of 9 at the time of this visit. The facility was found in compliance with the state law in regard to sprinkler coverage and was found not in compliance with the state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/11/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0032 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 Based on observation and interview, the facility failed to ensure 2 of 2 smoke compartments were provided with at least one exit providing a continuous path of travel to an exit discharge. This deficient practice affects all occupants in the facility. Findings include: Based on observations with the Administrator during a tour of the facility from 10:30 a.m. to 10:55 a.m. on 07/10/12, the TCU has two emergency exits. One exit is a horizontal exit into the adjacent smoke compartment. The adjacent smoke compartment has two exit stairwells. The second exit is an exit stairwell that does not connect to an exit discharge directly to the exterior. Based on interview at the time of the observations, the Administrator acknowledged each smoke compartment is not provided with at least one exit discharging directly to the exterior of the building. 3.1-19(b)	K0032	K 032 It is the practice of this Unit to abide by the Life Safety Code determined appropriate for this Unit. 1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice; **This provider completed an assessment by Fire Safety Evaluation System (FSES) to demonstrate equivalent compliance. NOTE : UPDATED FSES ATTACHED** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; **All residents located on the 4 th floor have the potential to be affected this alleged practice.** 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Systemic changes include Quality Assurance environmental tours will be conducted to evaluate the safety of these exits. FSES audit will be completed when structural changes are made to this Unit.** 4. How the corrective action(s) will be monitored to	08/02/2012

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			ensure the deficient practice will not recur, **The Administrator and or designee will audit safety inspection forms for these stairwell exits to determine safe means of egress 5 times per week for 30 days then 5 times per month for 150 days then 3 times per month for 180 days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. The Hospital will up dated FSES survey when any life safety structural changes are made to this area.** 5. What date the systemic changes will be completed. **These systemic changes will be completed by 8/2/2012**	

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K0034 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 Based on observation and interview, the facility failed to provide a continuous protected path of travel to an exit discharge for 3 of 3 exits in accordance with LSC sections 7.2.3.5. LSC 7.2.3.5 requires every smokeproof enclosure shall discharge into a public way, into a yard or court having direct access to a public way, or into an exit passageway. Such exit passageways shall be without openings other than the entrance from the smokeproof enclosure and the door to the outside yard, court, or public way. The exit passageway shall be separated from the remainder of the building by a two hour fire resistance rating. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on observations with the Administrator during a tour of the facility from 10:30 a.m. to 10:55 a.m. on 07/10/12, the fourth floor on which the TCU is located is divided into two smoke compartments and has three stairwell exits. Additionally, the fire resistance rating of the three exit enclosures on the	K0034	K 034 It is the practice of this Provider to abide by the Life Safety Code determined appropriate for this Unit. 1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice; **This provider completed an assessment by Fire Safety Evaluation System (FSES) to demonstrate equivalent compliance. NOTE; UPDATED FSES SURVEY ATTACHED** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; **All residents located on the 4 th floor have the potential to be affected this alleged practice.** 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Systemic changes include Quality Assurance environmental tours will be conducted to evaluate the safety of these exits. FSES audit will be completed when structural changes are made to this Unit/ or as requested.** 4. How the corrective action(s) will be monitored to ensure the	08/02/2012

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	first floor of the hospital to the exit discharge door is less than two hours. Based on interview at the time of observation, the Administrator acknowledged each of the three exit discharge passageways are not separated from the remainder of the building by a two hour fire resistance rating. 3.1-19(b)		deficient practice will not recur, **The Administrator and or designee will audit safety inspection forms for these stairwell exits to determine safe means of egress 5 times per week for 30 days then 5 times per month for 150 days then 3 times per month for 180 days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months. After 100% compliance is reached the QA committee will determine the frequency of continued monitoring. The Hospital will up dated FSES survey when any life safety structural changes are made to this area.** 5. What date the systemic changes will be completed. **These systemic changes will be completed by 8/2/2012**	

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K9999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident ' s room before July 1, 2012. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to install smoke detectors in 13 of 13 resident rooms before July 1, 2012. This deficient practice could affect 9 residents in the facility. Findings include: Based on observation with the	K9999	K9999 It is the practice of this provider to abide by Environment and Physical Standards 1. What corrective action(s) will be accomplished for those patients found to have been affected by the deficient practice; **Smoke detectors will be installed in each patient room** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; **All residents located on the 4 th floor have the potential to be affected this alleged practice.** 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; **Systemic changes include Quality Assurance environmental tours will be conducted to evaluate the safety of these patient rooms.** 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, **The Administrator and or designee will audit safety inspection forms for patient room 5 times per week for 30 days then 5 times per month for 150 days then 3 times per month for 180 days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months.**	07/27/2012

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	Administrator during a tour of the facility from 10:30 a.m. to 10:55 a.m. on 07/10/12, smoke detectors are not installed in resident sleeping rooms. Based on interview at the time of observation, the Administrator acknowledged smoke detectors are not installed in resident sleeping rooms. 3.1-19(ff)		**After 100% compliance is reached the QA committee will determine the frequency of continued monitoring.** 5. What date the systemic changes will be completed. **These systemic changes will be completed by 7/27/2012**	